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OBJECTIVES: To assess the associations between body mass index (BMI), leisure time physical activity (LTPA) and health-related quality of life (HRQL) trajectories among adults. **METHODS:** Data were drawn from the Canadian National Population Health Survey, with respondents being interviewed every two years between 1996/97 and 2006/07. Using growth curve modeling, HRQL trajectories for individuals aged 18 and over were associated with measures of BMI and LTPA. Growth models were conducted separately for males and females. **RESULTS:** Findings suggested that, for males, BMI categories had little impact on baseline HRQL, and no impact on the rate of change in HRQL as men aged. Among women, higher BMI categories were associated with significantly lower baseline HRQL. However, BMI had no impact on the rate of change of HRQL. In contrast, LTPA had significant impacts on baseline HRQL, as well as the rate of change in HRQL, with individuals who were inactive or sedentary having much steeper declines in HRQL as they aged, as compared to individuals who were active in their leisure time. This was true for both men and women, regardless of BMI category. **CONCLUSIONS:** The results underscore the importance of LPTA in shaping trajectories of HRQL.

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ECONOMIC PERFORMANCE AND EPIDEMIOLOGICAL TRANSITION IN MEXICO

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OBJECTIVES: To analize the relationship between the economic performance and the epidemiological transition in Mexico for the period from 1985 to 2008 **METHODS:** Data on Gross State Product (GSP) per capita and Gross Domestic Product (GDP) per capita were drawn from both unofficial and official sources, while mortality data by causes were extracted from vital statistics. Causes of death were grouped in communicable and non communicable diseases, excluding cancer because of the infectious etiology of some types of cancer. The epidemiological profile at state level was measured by dividing the mortality rate by communicable diseases between the mortality rate by non communicable diseases. So a value greather than one of this ratio reveals a predominance of communicable diseases and hence an epidemiological lag. Scatter plots and correlation coefficients were used to analize the data. **RESULTS:** Throughout the study period a negative correlation was observed between the GDP per capita and the mortality rate by communicable diseases, while a positive correlation was observed between the GDP per capita and the mortality rate by non communicable diseases. On the other hand, the correlation between the epidemiological profile at state level and the GSP per capita for 1985 was negative but moderate ($r = -0.53$), but for 2008 the correlation between the same variables almost disappears ($r = -0.029$). **CONCLUSIONS:** For the whole country the relationship of both time series suggests interactions between economic performance and mortality by causes, but within the country the results reveal convergence of mortality running independently of economic performance. This evidence may support the design of public policies to reduce inequalities in health.

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SOCIOECONOMIC INEQUALITIES CONCERNING THE SELF-RATED HEALTH STATUS IN GREECE: A COMPARATIVE ANALYSIS OF POST-CRISIS EFFECTS

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OBJECTIVES: To examine the socioeconomic inequalities regarding the self-rated health status in 2006 and in 2011. Thus, a comparison between the findings will highlight the changes concerning this topic in times of economic crisis. **METHODS:** The research is based on two cross-sectional surveys, which took place in 2006 and in 2011, and the sample size was 4003 and 6569 respectively. Moreover, a random, stratified sampling was applied in both cases, which took into account the age, the gender, the urbanization rate and the geographical region. **RESULTS:** Initially, the self-rated health status was measured with a Likert scale (1: very bad, 2: bad, 3: moderate, 4: good, 5: very good). However, it was dichotomized into two major scales (0: very bad, bad and moderate, 1: good and very good), in order to facilitate the methodology. Afterwards, the Concentration Index (Ranking Variable: Income) was estimated at 0.08 in 2006. The same procedure was repeated in 2011, and the new Concentration Index was approximately 0.07. **CONCLUSIONS:** Despite the fact that the small positive values of this index (which approximate the zero) do not indicate important inequalities, there are some key conclusions concerning these findings. Specifically, it is noteworthy that the high-income people seem to have a higher health status. In addition, the decrease of the Concentration Index in 2011 highlights the impact of economic crisis on health status of middle and upper class.

HEALTH CARE USE & POLICY STUDIES - Prescribing Behavior & Treatment Guidelines

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CHARACTERISTICS OF PATIENTS NOT CONSUMING PHARMACOLOGICAL RESOURCES DUE TO A LACK OF DRUG PRESCRIPTION DURING THEIR HOSPITAL ADMISSION

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OBJECTIVES: A high proportion of patients consume pharmacological resources during a hospital admission but little is known about the characteristics of those not receiving a drug prescription (DP).The aim was to assess independent patient's factors related to a non-DP during admission. **METHODS:** Retrospective observational study including all patients admitted in a teaching hospital during 2010. Exclusion criteria: direct admission at the Intensive Care Unit. Data collected: patients with and without a DP , demographics, programmed or urgent admission, Charlson score, length of hospital stay (LOS), type of Drug Related Group (DRG) (medical or surgical), DRG weight, readmission, mortality. Statistical analysis: Univariate analysis were performed, using Chi-Square test, Fisher exact Test and Mann-Whitney U test. A binary logistic regression was applied to identify independent factors and the model was assessed with the area under the receiver operating characteristics (ROC) curve (AUC). **RESULTS:** Patients: 16,485. Included: 15,750. Without a DP: 1,822 (11,6%) . Univariate: Patients with and without a DP; Age: 55,40 (+24,26) vs 23,70 (+ 29,8)($p<0.001$); Male: 6830(49.0%) vs 972(53.3%)($p<0.001$). Urgent admission: 5,183(37.2%) vs 1,334(73.2%)($p<0.001$); Charlson (0): 7,724(51.1%) vs 1,522(83.5%)($P<0.001$). LOS: 8.18 (+10.00) vs 1.67(+1.63)($p<0.001$), medical DRG: 8,743 (62.8%) vs 1,529(83.9%)($p<0.001$); DRG weight: 1.79(+1.70) vs 0.84 (+1.55)($p<0.001$); Readmission: 3.786(27.2%) vs 194(10.6%)($p<0.001$); mortality: 383(2.7%) vs 47(2.6%)($p=0.675$). Independent factors related to non-DP: age < 18 years (OR: 8.338, CI95%: 7.123-9.760, $p<0.001$), Urgent admission: (OR: 4.830, CI95%: 4.172-5.592, $p<0.001$), Charlson 0: (OR: 1.625, CI95%: 1.372-1.925, $p<0.001$), LOS < 2 days (OR: 13.711, CI95%: 11.701-16.066, $p<0.001$), medical DRG: (OR: 2.772, CI95%: 2.354-3.264, $p<0.001$). AUC: 0.917 (CI95%: 0.910-0.924, $p<0.001$). **CONCLUSIONS:** Paediatric population, an urgent admission, a low comorbidity status, a short LOS and a medical DRG were independent factors related to a non-DP during hospital admission. These patients could be managed in an ambulatory setting, what would help to reduce the economic burden in hospitals.

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VALIDITY OF SELF-REPORTED HEALTH CARE UTILIZATION: TOWARDS A RESEARCH CONSENSUS

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OBJECTIVES: Health care costs are often estimated using self-reported health care utilization data. The validity of these estimates is, however, challenged by the validity of self-reported data. The objectives were: (1) to review research findings on the validity of self-reported health care utilization focusing on factors affecting it; (2) to delineate implications for future research. **METHODS:** A systematic literature search was conducted in relevant literature databases. The identified publications were screened by predefined inclusion and exclusion criteria. Information on the accuracy of self-reported health care utilization was extracted from all included publications and analyzed. **RESULTS:** Te accuracy of self-reporting varies strongly across different types of resource use. Underreporting appears to be the most common problem and increases with the frequency use and length of recall period. Comparisons across studies are difficult because of substantial heterogeneity in study populations, measurement methods and validation approaches ("gold standard" used, definition of agreement between self-reports and other data sources). Most identified validation studies are characterized by non-experimental designs. Consequently, the influence of modifiable attributes of data collection (e.g. recall period) on the accuracy of self-reported data can only be analyzed by comparison among different studies. **CONCLUSIONS:** More experimental studies are needed to better quantify the impact of modifiable attributes of data collection, such as for example different recall periods and modes of questionnaire administration, on quality of self-reported health care utilization.

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EVALUATION OF PRESCRIBING PRACTICES OF CLINICIANS IN GOVERNMENT TEACHING HOSPITAL IN PAKISTAN

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OBJECTIVES: Irrational prescribing is a usual practice in developing countries like Pakistan. To analyze the prescribing pattern including both the layout of prescription and types of drugs prescribed by the doctors in a government teaching hospital in Pakistan. **METHODS:** Prescriptions ($n = 830$) from a government teaching hospital were collected randomly over a period of three months and evaluated retrospectively. The data were analyzed to assess the quality of prescription including both the layout and types of drug prescribed following the guidelines of WHO. **RESULTS:** Assessment of prescriptions revealed that the quality of layout of the prescriptions was unsatisfactory. Clarity of written instructions on how to take the medicines was inadequate. 41% of the prescriptions were without the age of the patient which includes 23% of pediatric prescriptions. Thirteen percent (13%) of medicines were prescribed with their uncommon abbreviated names. The average numbers of drugs per prescription were found to be 3.57. Seventy seven percent (77%) of the drugs were prescribed with their generic names. Polypharmacy was the norm, with more than half (53.9%) of the prescriptions containing at least 3 medicines. Twenty eight percent (28%) of prescriptions included vitamin preparations and 33% of analgesics/antipyretics. Penicillins, Cephalosporins, Quinolones Metronidazole and Tetracyclines were commonly prescribed antimicrobials, respectively. The high-priced antimicrobials were frequently prescribed without culture and sensitivity studies. **CONCLUSIONS:** This study concludes that quality of prescriptions in terms of layout and content of the drugs prescribed is inadequate requiring continued medical education. To enhance the legibility computer generated prescriptions should be promoted.